MDR Tracking Number: M5-04-0646-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-30-03.

The IRO reviewed hand neurology, muscle testing, office visits, myofasical release, therapeutic exercises, joint mobilization, and office visits with manipulations rendered from 02-27-03 through 04-10-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for hand neurology, muscle testing, office visits, myofasical release, therapeutic exercises and office visits with manipulations. Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($1785.00). **The requestor did not prevail** on the issues of medical necessity for joint mobilization. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-21-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
04-16-03	97750FC	$420.00	0.00	E	$100.00 per hour		A TWCC 21 was filed disputing entitlement to benefits for diagnosis submitted no resolution is show in TWCC system therefore reimbursement is not recommended
TOTAL		$420.00					The requestor is not entitled to reimbursement

This Decision is hereby issued this 26th day of April 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 02-27-03 through 04-10-03 in this dispute.

This Order is hereby issued this 26th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

January 20, 2004 **Amended January 22, 2004**

MDR Tracking #: M5-04-0646-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient was working on a steel wire machine repairing the wires when he accidentally amputated his right index finger just distal to the DIP joint. In the same accident, his wrist was apparently crushed in the machine. The patient was initially treated with emergency care and began treatment at ___ about 2 weeks post-injury. Treatment consisted of active and passive therapies along with manipulation. The patient was found to be at MMI with 6% impairment by ___ on May 13, 2003, about ___ post-injury. The treating clinic's records indicate large numbers of increases in ranges of motion and strength from February 27th to April 9th of 2003. The position statement by the treating clinic indicates that total treatment time was about ___. Records from the carrier generally duplicated those of the requestor, with the exception of a short cover letter from ___ of the carrier's representative. No peer review was presented for consideration.

DISPUTED SERVICES

Under dispute is the medical necessity of hand neurology, muscle testing, office visits, myofascial release, therapeutic exercises, joint mobilization and office visits with manipulation.

DECISION

The reviewer agrees with the prior adverse determination on joint mobilization.

The reviewer disagrees with the prior adverse determination for all other treatment rendered.

BASIS FOR THE DECISION

The requestor certainly exceeded the necessary documentation for the purpose of demonstrating medical necessity in this case. The case was treated quite conservatively, with only about 8 weeks of care for an amputation and crush injury to the hand. Any reasonable guidelines would certainly confirm that these injuries are serious enough to require at least the amount of treatment rendered by the providers on this case.

There was no evidence presented by the carrier in either the form of empirical studies or a peer review opinion that would counter the extensive documentation of medical necessity on this case. The provider did bill for joint mobilization after also having billed for manipulation. These are duplicate services, which should not be billed separately. Otherwise, the treatment program was not only reasonable; it was fairly conservative in the time constraints given.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,